

028156

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 1 8 9 1

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Lemuel Albritten			2a. DATE OF DEATH MONTH DAY YEAR 1 16 86			2b. HOUR 3:25 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 19 20		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.			
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Propellent Maker-GOV'T.		12b. KIND OF BUSINESS OR INDUSTRY U.S.	
13a. STATE Maryland			13b. COUNTY Charles		13c. CITY OR TOWN La Plata		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST James W Albritten			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Miles			13e. STREET ADDRESS / ZIP CODE Box 1646 St Marys Avenue 20646			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II		17. INFORMANT ADDRESS Box 1646 Patricia B. Albritten, La Plata, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Irreversible Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Atrial fibrillation with independent ventricular response 6 months DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from Oct 26 1986 to Jan 16 1986, that (I) (we) lost saw the deceased alive on Jan 15 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE Arthur O. Wooddy M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1-16-86	
22b. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS Box 430 Jarwood Clinic La Plata, Md. 20646				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 01/20/86		23c. NAME OF CEMETERY OR CREMATORY TRINITY MEM. GRDNS		23d. LOCATION CITY OR TOWN COUNTY STATE WALDORF CHARLES MD.		
24. FUNERAL DIRECTOR NAME ADDRESS AREHART FUNERAL HOME, INC., LAPLATA, MD.					25a. DATE REC'D. BY REGISTRAR JAN 23 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon copy of this certificate and attach it to the back of page 1. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Box 1048  
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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Roy Charles Arehart</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 8, 1986</b>		2b. HOUR a. <b>3:03 M</b>						
3 SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 27, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.					
10. CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mortician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Funeral Service</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Charles County</b>		13c. CITY OR TOWN <b>La Plata</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Box 66, Fairgrounds Road (20646)</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles H. Arehart</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lena Mitchell</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Cludine L. Arehart - Same As #13 A-E</b>		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Obstructive Pulmonary Disease</b>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Osteoporosis</b>											
19a. DATE OF OPERATION <b>6/21</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>6/21</b> , 19 <b>71</b> , to <b>1-8</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>1-7</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Henry J. Burke, M.D.</b>				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-8-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Henry Burke, M.D.</b>				22e. ADDRESS <b>La Plata, Md. 20646</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>January 9, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clinton, Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Lee Funeral Home, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 9 1986</b>		25b. REGISTRAR'S SIGNATURE <b>W. J. Anderson-Randall</b>					
ADDRESS <b>Old Alexander Ferry Road, Clinton, Maryland</b>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bessie Hall Bainbridge			2a. DATE OF DEATH MONTH DAY YEAR January 25, 1986		2b. HOUR 10:40 PM				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12/22/1897		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CHARLES MD.			
10. CITY OR TOWN OF DEATH La Plata, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN TAKOMA PK.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8018 BARON STREET 20912	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE HALL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA UNAVAILABLE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT Daughter		ADDRESS Rt. 3, Bx. 367 BETTY B. HUMMER Mechanicsville, MD			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypotension</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gastrointestinal bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Recurrent colon cancer</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Metastatic cancer of colon</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/24/1986</u> to <u>1/25/1986</u> , that (I) (we) lost saw the deceased alive on <u>1/25/1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) not view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/26/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Khadar Baig				22e. ADDRESS La Plata, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1/27/86		23c. NAME OF CEMETERY OR CREMATORY Huntt Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf, Charles, MD			
24. FUNERAL DIRECTOR NAME ADDRESS HUNT FUNERAL HOME, WALDORF, MD 20601				25a. DATE REC'D. BY REGISTRAR JAN 28 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

COMMUNICATIONS

SECTION

REPORT

DATE

NO.

PROJECT

DESCRIPTION

REMARKS

BY

DATE

NO.

REMARKS

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Adele Murray Baroody</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 17, 1986</b>		2b. HOUR <b>7:07 A.M.</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 14, 1900</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Lebanon</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		
10 CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.		
13a. STATE <b>Md.</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Bryans Road</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Unknown Thome</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>231-16-3191</b>		17 INFORMANT ADDRESS <b>Edward E. Baroody Same As #13</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE CARDIAC FAILURE</b> DUE TO OR AS A CONSEQUENCE OF (b) <b>BILATERAL PNEUMONIA</b> DUE TO OR AS A CONSEQUENCE OF (c) <b>DIABETES MELLITUS, CHRONIC OBSTRUCTIVE LUNG DISEASE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <b>1/14/86</b> 19, to <b>1/17/86</b> 19, that (I) (we) last saw the deceased alive on <b>1/16/86</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If none) (did not) view the body after death.						
22b. SIGNATURE <b>Sanjeeb K. Mishra</b>		DEGREE		22c. DATE SIGNED <b>1/17/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sanjeeb K. Mishra, M.D.</b>		22e. ADDRESS <b>Charles Prof. Center, #200, Waldorf, Md. 20601</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-20-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakwood Cemetery</b>		
24 FUNERAL DIRECTOR NAME <b>Joseph W. Bliley F.H. Richmond, Virginia</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Richmond, Virginia</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 23 1986</b>		
25b. REGISTRAR'S SIGNATURE <b>John E. Fisher</b>						

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of Pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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March 14, 1960  
U.S.A.  
Harris  
March 14, 1960  
U.S.A.  
Harris  
March 14, 1960  
U.S.A.  
Harris



Richmond, Virginia  
March 14, 1960  
U.S.A.  
Harris



020272

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Selena Marie Bradley</i>										20. DATE KNOWN OF DEATH MONTH <i>1</i> DAY <i>12</i> YEAR <i>86</i>		2b. HOUR <i>2:05 A</i>	
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH <i>6</i> DAY <i>18</i> YEAR <i>64</i>		6. AGE (IN YEARS) LAST BIRTHDAY <i>21</i> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH <i>1</i> DAY <i>12</i> YEAR <i>86</i>		2d. HOUR <i>2:05 A</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Charles County</i>	
10. CITY OR TOWN OF DEATH <i>La Plata</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Physicians Memorial Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>Dancer</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Entertainment</i>	
13a. STATE <i>VA</i>				13b. COUNTY <i>Arlington</i>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS <i>4813 S. 13th Street - 22204</i>	
14. FATHER'S NAME FIRST <i>Thomas</i> MIDDLE <i>Jack</i> LAST <i>Bradley</i>						15. MOTHER'S MAIDEN NAME FIRST <i>Barbara</i> MIDDLE <i>Jean</i> LAST <i>Thorpe</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>225-13-3591</i>				17. INFORMANT <i>Mother - Barbara J. Bradley</i>				ADDRESS <i>4813 S. 13th - St. Arlington</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive Head Injury</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <i>Motor Vehicular Accident</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION _____				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <i>1:34</i> A.M. MONTH <i>1</i> DAY <i>12</i> YEAR <i>86</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Motor Vehicular Accident</i>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Rt 3501</i>				21f. LOCATION STREET <i>Rt 3501</i> CITY OR TOWN <i>Faulkner</i> COUNTY <i>Charles</i> STATE <i>MD</i>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>David N. Gingrich</i>				TITLE (SPECIFY) <i>Assistant</i>				MEDICAL EXAMINER <i>DAVID N. GINGRICH</i>				DATE SIGNED <i>1/12/86</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>DAVID N. GINGRICH</i>				ADDRESS <i>5019 Woodhaven Dr., La Plata, MD 20646</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>1/16/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ivy Hill Cemetery</i>				23d. LOCATION CITY OR TOWN <i>Alexandria</i> COUNTY <i>Virginia</i> STATE <i>Virginia</i>			
24. FUNERAL DIRECTOR NAME <i>Malcolm O. Daynes</i>				ADDRESS <i>DEMAND F. H. S. INC. ALEXANDRIA, VA 22314</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 16 1986</i>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

*[Faint handwritten notes and markings at the bottom of the page, including what appears to be a signature or set of initials.]*

016113

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Charles Russell Cox			2a DATE OF DEATH MONTH DAY YEAR January 10, 1986		2b HOUR 5:30aM	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR March 31, 1903		
6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Charles MD.				
10 CITY OR TOWN OF DEATH La Plata		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		
12b KIND OF BUSINESS OR INDUSTRY Gas Co.		13a STREET ADDRESS / ZIP CODE Rt-2 Box-142 / 20675				
13b COUNTY Charles		13c CITY OR TOWN Pomfret		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME Charles H. Cox		15 MOTHER'S MAIDEN NAME Anna Mae Spalding				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 220-26-6809		17 INFORMANT Gertrude R. Cox same as #13		
18 CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma both lungs</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>carcinoma of the urinary bladder</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>12/26</u> , 19 <u>85</u> , to <u>1/10</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>1/9</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <u>Arturo Monteiro M.D.</u>		DEGREE M.D.		22c DATE SIGNED 1/10/86		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Arturo Monteiro, M.D.		22e ADDRESS La Plata, Md. 20646				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 1-13-86		23c NAME OF CEMETERY OR CREMATORY St. Joseph's Cem.		
23d LOCATION CITY OR TOWN COUNTY STATE Pomfret, Charles, Md.		24 FUNERAL DIRECTOR NAME Huntt Funeral Home				
24b ADDRESS P.O. Box 156 Waldorf, Md 20601		25a DATE REC'D. BY REGISTRAR JAN 13 1986		25b REGISTRAR'S SIGNATURE <u>J. A. Anderson</u>		

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

01897

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Lula M. Creamer</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 11, 1986</b>		2b. HOUR a. <b>3:35</b> M				
3 SEX <b>female</b>		4 RACE <b>caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>March 07, 1911</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Columbia, PA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.			
10 CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a STATE <b>MD</b>		13b COUNTY <b>Charles</b>		13c CITY OR TOWN <b>Waldorf</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>5003 Merrymount Court 20601</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Melvin Broome</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mabel Hines</b>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b SOCIAL SECURITY NO. <b>N/A</b>	
17 INFORMANT (husband) <b>Miles Creamer</b>			ADDRESS <b>5003 Merrymount Ct. Waldorf, MD 20601</b>			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coma.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebrovascular Accident.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Restrictive and obstructive Lung Disease, Dementia.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <b>1-6-1986</b> , to <b>1-11-1986</b> , that (I) (we) last saw the deceased alive on <b>1-11-1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b SIGNATURE <b>Girija Rath</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>1-11-86</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Girija Rath, M.D.</b>		22e ADDRESS <b>Waldorf, Md. 20601</b>		23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>Jan. 14, 1986</b>		23c NAME OF CEMETERY OR CREMATORY <b>Washington National Cem.</b>	
23d LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Prince George's, MD</b>		24 FUNERAL DIRECTOR NAME <b>Lee Funeral Home, Inc.</b>		25a DATE REG'D BY REGISTRAR <b>JAN 16 1986</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>			
25c ADDRESS <b>Old Alexander Ferry Rd., Clinton, MD 20735</b>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		3a. TIME OF DEATH	
CHARLES WILLIAM DASHER		January 21, 1986		6:20AM	
4. SEX		5. RACE		6. DATE OF BIRTH	
Male		Caucasian		August 28, 1908	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
South Dakota		USA		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH Waldorf		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1023 Dorset Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Lusby	
14. FATHER'S NAME FIRST MIDDLE LAST Otis Dasher		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Sharrar		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) *****		17. INFORMANT ADDRESS 1023 Dorset Dr Laverne H. Dasher Waldorf, Md 20601		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) This hospital attended the deceased from _____ to _____, that (1) (we) lost _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)		22b. SIGNATURE DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Haiduk		22e. ADDRESS Clinton, Md		22f. DATE SIGNED 1/24/86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/23/86		23c. NAME OF CEMETERY OR CREMATORY Trinity Mem Gardens	
23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf, Charles, Md.		24. FUNERAL DIRECTOR NAME Huntt Funeral Home		25a. DATE REC'D. BY REGISTRAR JAN 27 1986	
25b. REGISTRAR'S SIGNATURE June W. W. W.		25c. REGISTRAR'S NAME June W. W. W.		25d. REGISTRAR'S ADDRESS June W. W. W.	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

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**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before

### MEDICAL CERTIFICATION

BP.







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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#13, FilmG611 1/13/86 kam

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

01899

1-  
FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Leolyn Corrine Downs</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 7, 1986</b>			2b. HOUR <b>4:35 M</b>			
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Dec 29 1912</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>73</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.			
10 CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>	
13a. STATE <b>Georgia</b>		13b. COUNTY <b>Richmond</b>		13c. CITY OR TOWN <b>Augusta</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2208 Central Ave. / 30904</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>James Turner Cook</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Betsy Lilly</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No - - -</b>					
16b. SOCIAL SECURITY NO. <b>578-22-5707</b>		17 INFORMANT ADDRESS <b>Edward A. Burnap, Jr. 1308 Malbay Dr. Lutherville, Md</b>							
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>liver cancer</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <b>liver cancer</b>									
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) <b>N/A.</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>N/A</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>N/A</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>12-27</b> , 19 <b>85</b> , to <b>1-7</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>1-6-87</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>ABH</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1-7-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Abdul H. Fadul, M.D.</b>				22e. ADDRESS <b>La Plata, Md. 20646</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11 Jan 86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Memorial Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waldorf, Charles, Md.</b>			
24 FUNERAL DIRECTOR NAME ADDRESS <b>Huntt Funeral Home Waldorf, Md 20601</b>				25a. DATE RECEIVED BY REGISTRAR <b>JAN 9 1986</b>		25b. REGISTRAR'S SIGNATURE <b>J. H. [Signature]</b>			

BP

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2025 JAN 3 1980

JAN 3 1980

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

009056

1. DECEASED NAME (TYPE OR PRINT) <b>Lorraine S. Gaertner</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 6, 1986</b>			2b. HOUR a. <b>2:07 M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 8 06</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.			
10. CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Keypunch</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>I.B.M.</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Clinton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arley C. Hawkins</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lula Hess</b>			13e. STREET ADDRESS / ZIP CODE <b>8600 Mike Shapiro Cr. 20735</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578-07-9234</b>		17. INFORMANT <b>Ms. Mary Kilby</b>		ADDRESS <b>Rt. 2, Box 272A Pomfret, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>pulmonary edema</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 min</b> <b>24 hr</b> <b>36 hr</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>arteriosclerotic Heart Disease, pacemaker, gastroenteric dehydration, sepsis</b>									
19a. DATE OF OPERATION <b>none</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>in 12</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12 12 85</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) <b>in 1A</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>in 1A</b>		21f. LOCATION CITY OR TOWN COUNTY STATE <b>in A</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>12/16, 1985</b> to <b>1/6/1986</b> , that (I) (we) lost saw the deceased alive on <b>1/5</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Paul Pritchett M.D.</b>				DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/6/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Paul Pritchett, M.D.</b>				22e. ADDRESS <b>La Plata, Md. 20646</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>1/6/86</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 8 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the properties. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified (phone).

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Item 2a ep phone 24186 STATE OF MARYLAND 8 6 0 1 9 0 1  
 1- STATE REGISTRAR  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
 Lewis Levie Hamilton

2a. DATE OF DEATH MONTH DAY YEAR  
 10/28/1986

2b. HOUR  
 6:38<sup>P</sup><sub>M</sub>

3. SEX  
 Male

4. RACE  
 Caucasian

5. DATE OF BIRTH MONTH DAY YEAR  
 Aug 6, 1919

6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.  
 66

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
 Maryland

7b. CITIZEN OF WHAT COUNTRY?  
 USA

8. MARRIED ☒ NEVER MARRIED ☐  
 WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
 Charles MD.

10. CITY OR TOWN OF DEATH  
 LaPlata

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
 Physicians Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
 Carpenter

12b. KIND OF BUSINESS OR INDUSTRY  
 Construction

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
 13a. STATE Maryland 13b. COUNTY Charles 13c. CITY OR TOWN Indian Head 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS / ZIP CODE #6 Gering Court / 20640

14. FATHER'S NAME FIRST MIDDLE LAST  
 Leroy Hamilton

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
 Amanda Viola Pickeral

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  
 No

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)  
 - - - 577-12-7516

17. INFORMANT ADDRESS  
 Dorothy Mae Hamilton \*Same as #13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
 PART I. DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) Acute myocardial infarction  
 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary heart disease  
 DUE TO, OR AS A CONSEQUENCE OF (c) \_\_\_\_\_  
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
 P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-26, 1986, to 1-28, 1986, that (I) (we) last saw the deceased alive on 1-28, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE  
Ignacio T. Garcia, M.D.

22c. DATE SIGNED  
1-28-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
 Ignacia Garcia, M.D.

22e. ADDRESS  
 La Plata, Maryland 20646

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
 Burial

23b. DATE  
 2-1-86

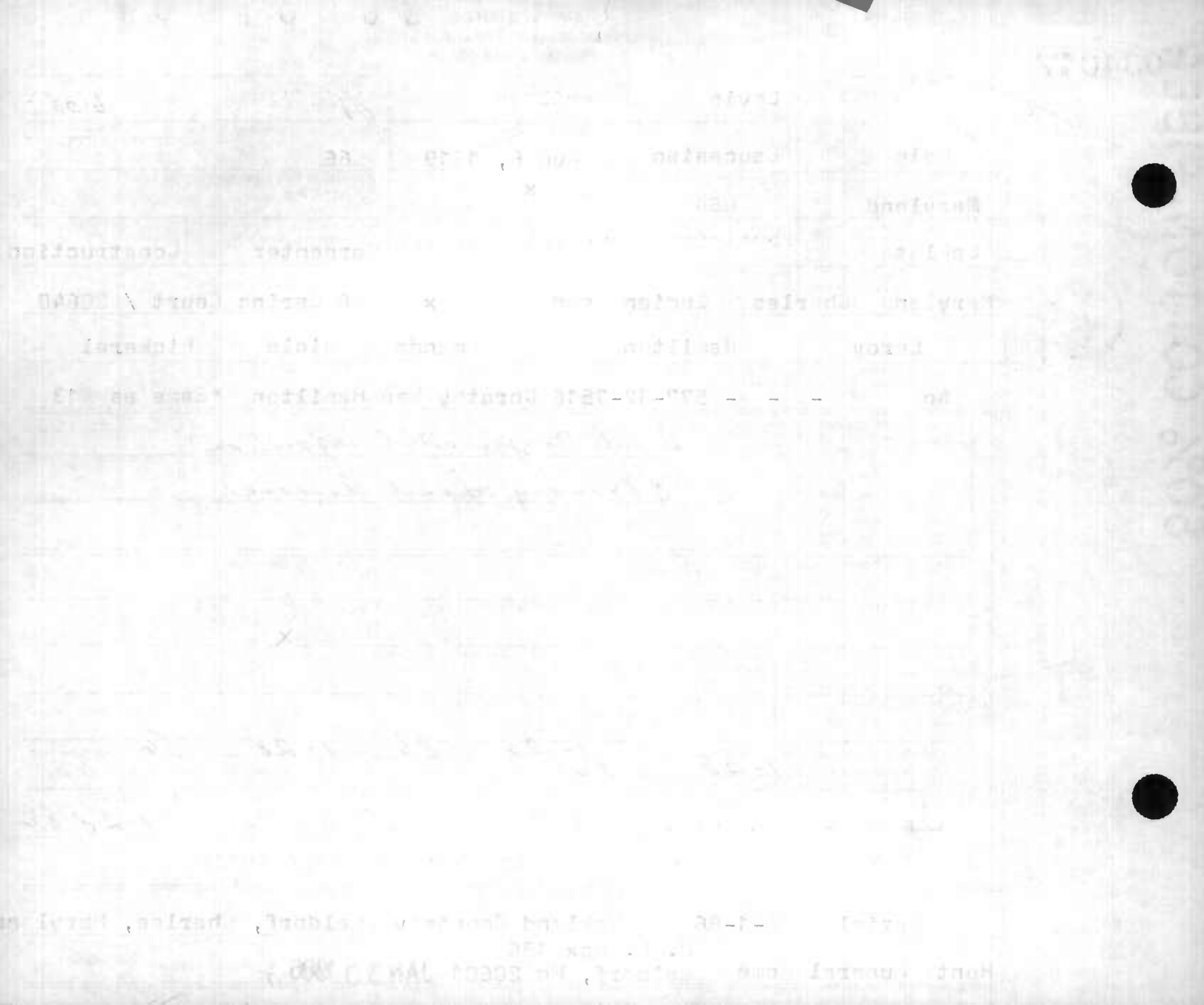
23c. NAME OF CEMETERY OR CREMATORY  
 Oakland Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE  
 Waldorf, Charles, Maryland

24. FUNERAL DIRECTOR NAME  
 Hunt Funeral Home

25a. DATE REC'D. BY REGISTRAR  
 JAN 30 1986

25b. REGISTRAR'S SIGNATURE  
John Davidson-Randall



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR 1 - STATE REGISTRAR		8 6 0 1 9 0 2	
1. DECEASED NAME (TYPE OR PRINT)		7a. DATE OF DEATH	
FIRST MIDDLE LAST <b>Cleveland L. Harris</b>		MONTH DAY YEAR <b>January 20, 1986</b>	
3 SEX		2b. HOUR	
<b>Male</b>		<b>3:08 AM</b>	
4 RACE		5. DATE OF BIRTH	
<b>Black</b>		MONTH DAY YEAR <b>5 19 '25</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		6 AGE (IN YEARS LAST BIRTHDAY)	
<b>North Carolina</b>		<b>60</b> YRS	
7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>USA</b>		9. BALTIMORE CITY OR COUNTY OF DEATH	
11. CITY OR TOWN OF DEATH		<b>Charles</b> MD.	
<b>LaPlata</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12b. KIND OF BUSINESS OR INDUSTRY	
<b>Physicians Memorial Hospital</b>		<b>School Board</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS?	
STATE COUNTY CITY OR TOWN <b>Maryland Prince Geo Brandywine</b>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		13e. STREET ADDRESS / ZIP CODE	
FIRST MIDDLE LAST <b>unknown</b>		<b>Rt. 1 Box 241 20613</b>	
15. MOTHER'S MAIDEN NAME		17. INFORMANT ADDRESS	
FIRST MIDDLE LAST <b>unknown</b>		<b>Marlean Gray</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
<b>NO</b>		<b>-</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hemoptyses</b>			
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Heavy Alcohol</b>			
DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Marked Carotid Artery, Dysphagia</b>			
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY	
		HOUR A.M. MONTH DAY YEAR <b>19</b>	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22a. I certify that (1) this hospital attended the deceased from <b>1-19</b> , 19 <b>86</b> , to <b>1-20</b> , 19 <b>86</b> , that (1) (we) last saw the deceased alive on <b>1-20</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.		22b. SIGNATURE	
		<b>Henry L. Burke MD</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. DATE SIGNED	
<b>/Dr. Henry L. Burke</b>		<b>1-20-86</b>	
22d. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	
<b>LaPlata, Md. 20646</b>		<b>Burial</b>	
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
<b>24 Jan '86</b>		<b>ST. THOMAS CH. CEM.</b>	
23d. LOCATION (CITY OR TOWN)		23e. DATE REC'D. BY REGISTRAR	
<b>BRANDYWINE, P.G., MD.</b>		<b>JAN 27 1986</b>	
24. FUNERAL DIRECTOR NAME		25. REGISTRAR'S SIGNATURE	
<b>Marcell Adams, Aquasco Md. 20608</b>		<b>John Davidson-Henderson</b>	

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use on the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and page 4 must be completed.

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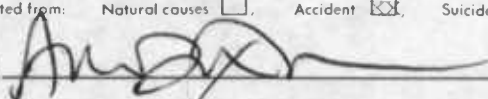
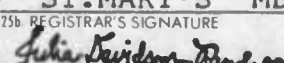


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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST NANCY		MIDDLE YVONNE		LAST HILL		2a. DATE KNOWN OF DEATH		X MONTH 1 DAY 3 YEAR 19 86		2b. HOUR			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MAY 8, 1939		6. AGE (IN YEARS) 46 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD 1 3 19 86 8P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA				7b. CITIZEN OF WHAT COUNTRY? U. S. OF A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Charles County MD			
10. CITY OR TOWN OF DEATH La Plata				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE				12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13b. COUNTY CHARLES		13c. CITY OR TOWN BRYANS ROAD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS MARSHALL HALL LOT #8, TRAILOR PARK 20616					
14. FATHER'S NAME FIRST EUGENE				MIDDLE C		LAST FULLER		15. MOTHER'S MAIDEN NAME FIRST MARGARET				MIDDLE STRAUCH		LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 183-30-4508		17. INFORMANT J. C. HILL, III, SON, INDIAN HEAD, MD. ADDRESS RT. 1 BOX 155W									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Smoke inhalation</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <u>6:48</u> P.M. MONTH <u>1</u> DAY <u>3</u> YEAR <u>1986</u>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Trailer fire.							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) trailer				21f. LOCATION STREET Marshall Hall Trailer Pk.		CITY OR TOWN Charles		COUNTY MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 1-5-86	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 01/07/86				23c. NAME OF CEMETERY OR CREMATORY SACRED HEART				23d. LOCATION CITY OR TOWN BUSHWOOD ST. MARY'S MD.			
24. FUNERAL DIRECTOR NAME AREHART FUNERAL HOME, INC., LAPLATA, MD.				ADDRESS				25a. DATE REC'D. BY REGISTRAR JAN 8 1986				25b. REGISTRAR'S SIGNATURE 			

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25M

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DHMH - 17  
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. BOSTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENALTY ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. ATTACH THIS CERTIFICATE TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESIDENT STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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*Handwritten signature or initials.*

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1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Benjamin Alfred Jackson			2a. DATE OF DEATH MONTH DAY YEAR January 30, 1986		2b. HOUR 12:00 P.		
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR NOV. 22, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CHARLES MD.	
10. CITY OR TOWN OF DEATH LaPlata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHAUFFEUR		12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT	
13a. STATE MARYLAND				13b. COUNTY CHARLES		13c. CITY OR TOWN NANJEMOY	
14. FATHER'S NAME BUNNY				15. MOTHER'S MAIDEN NAME MAMIE JACKSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Rt. 1 Box 71 William H. Bannister Nanjemoy, Md. 20662			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Conduction heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>1 hr</u> <u>5 days</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Left Bundle Branch Block, Angina pectoris, Hypertension, Anemia</u>							
19a. DATE OF OPERATION <u>N/A</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>N/A</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <u>N/A</u>			
21d. INJURY OCCURRED WHERE AT WORK <u>N/A</u> WHILE AT WORK <u>N/A</u>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>N/A</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>N/A</u>			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/8</u> 19 <u>78</u> to <u>1/30</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/27</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Dr. Paul Pritchett MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/30/1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Paul Pritchett				22e. ADDRESS LaPlata, Md. 20646			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE FEB. 3, 1986		23c. NAME OF CEMETERY OR CREMATORY EMMORY CH. CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE NANJEMOY CHARLES MD.	
24. FUNERAL DIRECTOR NAME THORNTON'S FUNERAL HOME				25a. DATE REC'D. BY REGISTRAR FEB 04 1986			
ADDRESS POMONKEY, Md.				25b. REGISTRAR'S SIGNATURE <u>John Darden</u>			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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NOTICE



009021

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>EUGENE AUGUSTINE JENKINS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 3, 1986</b>		2b. HOUR <b>6:18 a</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 8, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS. MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CHARLES</b> MD.	
10. CITY OR TOWN OF DEATH <b>LA PLATA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PHYSICIANS MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Powder Factory</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>Charles</b>	13c. CITY OR TOWN <b>Indian Head</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>RFD 1, Box 153 / 20640</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>John W. Jenkins</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Wright</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>----- 217-34-1211</b>	17. INFORMANT <b>Spouse</b> ADDRESS <b>Olga T. Jenkins same as 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> DUE TO, OR AS A CONSEQUENCE OF: (b) _____ DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Pneumonia 3 weeks</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>1-3</u> , 19 <u>85</u> , to <u>1-3</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>1-3</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Daniel Howell</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>1-3-86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANIEL HOWELL, M.D.</b>		22e. ADDRESS <b>LA PLATA, MARYLAND 20646</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>1/6/86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pomfret, Charles, MD</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Huntt Funeral Home, Inc., Waldorf, MD</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 6 1986</b>		
			25b. REGISTRAR'S SIGNATURE		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept for 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

024013

P. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) George Bowen Kirkpatrick			2a. DATE OF DEATH MONTH DAY YEAR January 19, 1986		2b. HOUR 4:25P M				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 8/10/16		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS # UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County MD.			
10. CITY OR TOWN OF DEATH LaPlata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Automobile		
13a. STATE MD			13b. COUNTY Charles		13c. CITY OR TOWN Indian Head		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST George B. Kirkpatrick			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Roberta C. Bowen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Son Stephen D. Kirkpatrick			ADDRESS 2710 Urbanna Dr. Wheaton, MD	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Septic Shock</u> DUE TO, OR AS A CONSEQUENCE OF <u>Pneumonia</u> (b) <u>Potential Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF <u>Advanced Degenerative Disease</u> (c) <u>Advanced Degenerative Disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>a</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3</u> 19 <u>85</u> to <u>1/19</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>11/17</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>G. HOWATAKEN</u>				22c. DATE SIGNED <u>1/19/86</u>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) G. HOWATAKEN				22f. ADDRESS LaPlata, MD 20646					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/23/86		23c. NAME OF CEMETERY OR CREMATORY Md. Vet. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, Pr. Geo., MD			
24. FUNERAL DIRECTOR NAME Hunt Funeral Home, Waldorf, MD 20601				25a. DATE REC'D. BY REGISTRAR JAN 22 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

01907

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE KNOWN OF DEATH				3. SEX				4. RACE				5. DATE OF BIRTH				6. AGE (IN YEARS)				7. IF UNDER 1 YR.				8. IF UNDER 24 HRS.				9. DATE PRONOUNCED DEAD				10. MONTH DAY YEAR				11. HOUR			
Charles Calvert Lancaster, Sr.				1/24/ 19 86				Male				White				12/21/1906				79				MONTHS DAYS HOURS MIN				HOURS MIN				1/ 24/ 19 86				9:04 A M							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY															
Maryland				U.S.A.								Charles County, MD				La Plata				Physician's Memorial Hospital				Farmer				Farming															
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS				13e. STREET ADDRESS				14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																			
Maryland				Charles				Rock Point				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				Stella Maris Drive, 20682				Simon Spearman Lancaster, Sr.				Verlinda Flizabeth Jenkins																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
No				212-36-7043				Helen S. Lancaster, Wife, Same As 13								PART I DEATH WAS CAUSED BY:																											
																IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease																											
																DUE TO, OR AS A CONSEQUENCE OF																											
																Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																											
																(b)																											
																DUE TO, OR AS A CONSEQUENCE OF																											
																(c)																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																20. AUTOPSY?																							
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																																											
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER																DATE SIGNED 1/25/86																							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																																							
Gregory R. Kauffman, M.D.				111 Penn St.																																							
23a. BURIAL, CREMATION, REMOVAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE																															
Burial				1/27/86				Holy Ghost Cemetery				Issue, Charles Co., Maryland																															
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR																25b. REGISTRAR'S SIGNATURE																							
Arenhart Funeral Home, Inc., La Plata, Md.				JAN 30 1986																Julia Davidson-Rendell																							

DIVISION OF VITAL RECORDS, 301 W. PRESTON BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENAL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. PAGE 5 SHOULD BE FILED WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Simon Spearman Lancaster</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 14, 1986</b>		2b. HOUR a. <b>3:58 M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 29 1903</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. OF A.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.		
10. CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FARMER</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>		13a. STREET ADDRESS / ZIP CODE <b>GENERAL DELIVERY 20682</b>				
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>CHARLES</b>		13c. CITY OR TOWN <b>ROCK POINT</b>		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>GENERAL DELIVERY 20682</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Simon SPEARMAN LANCASTER Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Verlinda Elizabeth JENKINS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219-48-8997</b>		17. INFORMANT ADDRESS <b>GENERAL DELIVERY MARY BELLE LANCASTER, ROCK PT., MD. 20682</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Lung obstructive disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cardio-Respiratory, Renal failure</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 12, 1986</i> to <i>Jan 14, 1986</i> , that (I) (we) lost saw the deceased alive on <i>Jan 13, 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Ignacio T. Garcia, M.D.</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-14-86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ignacio Garcia, M.D.</b>		22e. ADDRESS <b>La Plata, Md. 20646</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>01/17/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY GHOST CEMETERY</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>ISSUE CHARLES MARYLAND</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>AREHART FUNERAL HOME, INC., LA PLATA, MD.</b>				
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John Fisher</i>				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Mildred L. McKinney</b>			2a. DATE OF DEATH Month <b>JANUARY</b> Day <b>1</b> Year <b>1986</b>			2b. HOUR <b>2:55 PM</b>							
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>April 26, 1900</b>		6. AGE (In years last birthday) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>			
7a. BIRTHPLACE (State or foreign country) <b>Washington Dc.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Charles County</b> Md.						
10. CITY OR TOWN OF DEATH <b>LA PATA</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Physician Memorial</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>				
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>MD</b>			13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Issue</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RR 257 20645</b>				
14. FATHER'S NAME First <b>William</b> Middle <b></b> Last <b>Lee</b>			15. MOTHER'S MAIDEN NAME First <b>Grace</b> Middle <b></b> Last <b>Billings</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>168-28-6304</b>			17. INFORMANT Address <b>CLARENCE McKinney RR 257 Issue, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <b>12/30/85</b> , 19 <b></b> , to <b>1/1/86</b> , 19 <b></b> , that (I) (we) lost saw the deceased alive on <b>1/1/86</b> , 19 <b></b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Race</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1/2/85</b>					
22d. PHYSICIAN'S NAME (Type) <b>R. Timothy Pace, M.D.</b>						22e. ADDRESS <b>Waldorf Medical Park Rt 301S Box 8&amp;9, Waldorf, Md 20601</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1-3-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Ghost Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Issue Charles MD</b>							
24. FUNERAL DIRECTOR <b>DUNN &amp; Sons Funeral Home 2301 Mckinney SE.</b>						25a. REC'D BY REGISTRAR <b>JAN 3 1986</b>		25b. REGISTRAR'S SIGNATURE <b>J. J. J. J.</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5-15-90





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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

01910

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Agnes Owen			2a. DATE OF DEATH MONTH DAY YEAR 1 18 86			2b. HOUR 5:30p M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 4 10		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. OF A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.				
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY AT HOME		
13a. STATE MARYLAND			13b. COUNTY CHARLES		13c. CITY OR TOWN LA PLATA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE BOX 464 20646	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM FLOYD DIXON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA JOHNSON			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 219-56-1997	
17. INFORMANT ANN O. GARDINER, LA PLATA, MD.			ADDRESS BOX 464			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hepato-renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hepatocellular disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min 1 month 6 years			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>GI bleed, pneumonia, sepsis, seizure disorder, severe metabolic/respiratory acidosis</u>	
19a. DATE OF OPERATION 12/30/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Left side Rectal bleeding</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTINGENT <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) N/A		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A				
21e. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A		22a. I certify that (I) (this hospital) attended the deceased from 8/12, 1979, to 1/18, 1986, that (I) (we) last saw the deceased alive on 1/18, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				22b. DATE SIGNED 1/19/86		
22c. SIGNATURE Paul Pritchett MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Pritchett, MD	
22e. ADDRESS Charles St., La Plata, Md 20646			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 01/21/86		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART		
23d. LOCATION CITY OR TOWN COUNTY STATE LA PLATA CHARLES MD.			24. FUNERAL DIRECTOR NAME ADDRESS AREHART FUNERAL HOME, INC., LAPLATA, MD.			25. (A) (B) BY REGISTRAR (C) REGISTRAR'S SIGNATURE JAN 23 1986 John Gardner-Randall				

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>KIKO MARTEZ PROCTOR</b>			2a DATE OF DEATH MONTH DAY YEAR <b>1/10/86</b>		2b HOUR <b>8:00AM</b>						
3 SEX <b>Male</b>		4 RACE <b>American Indian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>June 9, 1982</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>3</b>		IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		IF UNDER 24 HRS HOURS MIN. <b>YRS.</b>	
7a BIRTHPLACE STATE OR FOREIGN COUNTRY <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>CHARLES COUNTY</b> MD.					
10 CITY OR TOWN OF DEATH <b>LA PLATA</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PHYSICIANS MEMORIAL HOSPITAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		12b KIND OF BUSINESS OR INDUSTRY <b>- - -</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE <b>Maryland</b>		13b COUNTY <b>Charles</b>		13c CITY OR TOWN <b>Waldorf</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>Hwy-867 Box-2038 / 20601</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Randy T. Proctor</b>						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Theresa L. Harley</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>- - -</b>		17 INFORMANT ADDRESS <b>Theresa L Proctor same as #13</b>							

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

**Cardiopulmonary Failure**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

**congenital**

**Congenital Cyanotic Heart Disease**

**(BILATERAL PULM. VEIN STENOSIS)**

**Pulmonary Hypertension, ASD**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

**U.R.I.**

MEDICAL CERTIFICATION

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>May 21, 83</b> to <b>Jan 86</b> , that (I) (we) lost saw the deceased alive on <b>Aug 15</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>Tahir Sait</b>				DEGREE <b>M.D. F.A.A.P.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>1/10/86</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>TAHIR SAIT</b>				22e ADDRESS <b>Waldorf, Maryland</b>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>1/14/86</b>		23c NAME OF CEMETERY OR CREMATORY <b>St. Charles Cem.</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Glymont, Charles, Maryland</b>	
24 FUNERAL DIRECTOR NAME <b>Hunt Funeral Home</b>				25a DATE REC'D. BY REGISTRAR <b>JAN 14 1986</b>		25b REGISTRAR'S SIGNATURE <b>Julia Davidson</b>	

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Robert William Pusey</b>			2a DATE OF DEATH MONTH DAY YEAR <b>January 30, 1986</b>		2b HOUR A. <b>11:39M</b>		
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Sept 24 1920</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS. MONTHS DAYS IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD	
10 CITY OR TOWN OF DEATH <b>LaPlata</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Upolster</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Upolstering</b>	
13a STATE <b>Maryland</b>		13b COUNTY <b>Charles</b>		13c CITY OR TOWN <b>Waldorf</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET ADDRESS / ZIP CODE <b>Hwy-9259, Box-335F / 20601</b>		14 FATHER'S NAME FIRST MIDDLE LAST <b>Robert William Pusey Sr.</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie Anna Beck</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS <b>Debra L. Rice Same as #13</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>16 min</b> <b>15 yrs</b> <b>25 yrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes mellitus, Polycystic Disease, Congestive Heart Failure</b>							
19a DATE OF OPERATION <b>n/a</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>n/a</b>		20a AUTO PSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTED TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>n/a</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>n/a</b>			
21d INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>9/27</b> 19 <b>83</b> to <b>1/30</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>12/31</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b SIGNATURE <b>Dr. Paul Pritchett MD</b>				DEGREE <b>MD</b>		22c DATE SIGNED <b>1/30/1986</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Paul Pritchett</b>				22e ADDRESS <b>LaPlata, Md. 20646</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>2/3/86</b>		23c NAME OF CEMETERY OR CREMATORY <b>Trinity Memorial</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Waldorf Charles MD</b>	
24 FUNERAL DIRECTOR NAME <b>Hunt Funeral Home</b>				ADDRESS <b>P. O. Box 156 Waldorf, Md 20601</b>		25a DATE REC'D. BY REGISTRAR <b>FEB 03 1986</b>	
				25b REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

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NAME: [illegible]  
ADDRESS: [illegible]  
CITY: [illegible]  
STATE: [illegible]  
ZIP: [illegible]  
TELEPHONE: [illegible]  
FAX: [illegible]  
E-MAIL: [illegible]  
DATE: [illegible]  
TIME: [illegible]

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Michael		MIDDLE Douglas		LAST Shorter		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH 1		DAY 5		YEAR 86		2b. HOUR 10 <sup>04</sup> AM											
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH 7		DAY 30		YEAR 67		6. AGE (IN YEARS) LAST BIRTHDAY 18 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH 1		DAY 5		YEAR 86		2d. HOUR 11 <sup>11</sup> AM							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles																							
10. CITY OR TOWN OF DEATH LaPlata		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physician Memorial Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter						12b. KIND OF BUSINESS OR INDUSTRY Private															
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																													
13a. STATE Maryland		13b. CITY OR TOWN Charles		13c. CITY OR TOWN Welcome		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Firetower Road/ 20693																					
14. FATHER'S NAME FIRST John						MIDDLE Shorter						15. MOTHER'S MAIDEN NAME FIRST Shirley						MIDDLE Ann						LAST Gray					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DAMAGES) -----				218-02-0159				17. INFORMANT ADDRESS John M. Shorter Welcome, Md. 2069																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8199 IMMEDIATE CAUSE (a) <u>craniocervical trauma, MVA</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH instant											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10 (P.M.) 5 Jan 1986						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) MVA																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street						21f. LOCATION STREET Rexley Rd. CITY OR TOWN Rexley Charles MD STATE																	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																													
ACTUAL SIGNATURE H.M. Nahan						TITLE (SPECIFY) M.D. Charles Co.						MEDICAL EXAMINER						DATE SIGNED 6 Jan 86											
EXAMINER'S NAME (TYPE OR PRINT) H.M. Nahan						ADDRESS CR #1 Box 1020 (LaPlata, Md) 20646																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 1-9-86		23c. NAME OF CEMETERY OR CREMATORY St. Catherine						23d. LOCATION CITY OR TOWN McConchie COUNTY Charles MD. STATE															
24. FUNERAL DIRECTOR Thornton Funeral Home										ADDRESS Pomonkey, Md.										25a. DATE REC'D. BY REGISTRAR JAN 13 1986		25b. REGISTRAR'S SIGNATURE John Nahan							

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/ B2

001030

RECEIVED  
FEB 11 1964

100-100000-100000



028178

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mary Rose Steele</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 20, 1986</b>		2b. HOUR <b>5:33</b> <sup>A</sup> <sub>M</sub>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 22, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maine</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.	
10. CITY OR TOWN OF DEATH <b>LaPlata</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Md.</b>	13b. COUNTY <b>Charles</b>	13c. CITY OR TOWN <b>La Plata</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	11. STREET ADDRESS / ZIP CODE <b>Rt. #488 20646</b> <b>Chas. Co. Nursing Home</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ernest Landry</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Elizabeth Godin</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>002-03-3460</b>		17. INFORMANT <b>1081 Woodberry Dr.</b> <b>Carolyn LeClair Bryans Road, Md. 20616</b>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary pul. artery aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral vascular accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis Hypoxemia</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>1/1</b> , 19 <b>86</b> , to <b>1/20</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Michael A. Leatherwood</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/20/1986</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Michael Leatherwood</b>		22e. ADDRESS <b>Waldorf, Md 20601</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>1-25-86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Meadowlawn Mem. Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Newport Richey, Fla.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Morgan Funeral Home Newport Richey, Florida</b>			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMM - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove complete pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

JAN 23 1986







029124

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Julian Swann			2a. DATE OF DEATH MONTH DAY YEAR January 21, 1986			2b. HOUR 5:00 P M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 1 10		6. AGE (IN YEARS (LAST BIRTHDAY)) 75 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD					
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.			13b. COUNTY Charles		13c. CITY OR TOWN Tisgah		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Gen. Delivery 20640		
14. FATHER'S NAME FIRST MIDDLE LAST Julian E. Swann				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora F. Swann							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-22-2441 →		17. INFORMANT ADDRESS Mr. James Swann 6213 Alpine St. District Hgts., Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 min		
									27 days		
									1 month		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>Sepsis, Dehydration, azotemia, Dementia, Cerebral infarcts, Diabetes</u>											
19a. DATE OF OPERATION N/A			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 1/19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N/A						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT HOME			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A						
22a. I certify that (I) (this hospital) attended the deceased from <u>12/20</u> , 19 <u>84</u> , to <u>1/21</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>1/20</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Paul Pritchett M.D.</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/21/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Pritchett M.D.					22e. ADDRESS La Plata, Md 20646						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 1/22/86		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Anatomy Board					ADDRESS Balto., Md.		25. DATE REC'D. BY REGISTRAR JAN 28 1986		26. REGISTRAR'S SIGNATURE <u>John R. Riddle</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This place remains the property of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



013061

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dalton Wood, Sr.			2a. DATE OF DEATH MONTH DAY YEAR January 1, 1986			2b. HOUR 9:30 P M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 12, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.			
10. CITY OR TOWN OF DEATH La Plata, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. COAST GUARD		12b. KIND OF BUSINESS OR INDUSTRY RETIRED		
13a. STATE MARYLAND		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN CALIFORNIA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 313 ST. ANDREWS LANE 20619	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM LARKIN WOOD				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA REBECCA BLAIR					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1926-1944		17. INFORMANT ADDRESS MRS. VALERIE H. WOOD, 261 KING DRIVE 20653 LEXINGTON PARK, MD.					
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetic Mellitus</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Recent Cerebral Vascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Renal insufficiency and Dehydration</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED: WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from 1/3/86 to 1/1/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If you did not view the body after death, so state.)									
22b. SIGNATURE <i>G. J. WATKINS</i>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/1/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. J. WATKINS			22e. ADDRESS LA PLATA, MD 20646						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1/4/86		23c. NAME OF CEMETERY OR CREMATORY RIVERSIDE PARK		23d. LOCATION CITY OR TOWN COUNTY STATE NORFOLK N/A VIRGINIA		
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.					25a. DATE REC'D. BY REGISTRAR JAN 9 1986				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs or sections, but the specific words and sentences are difficult to discern.]

3

017052

DIVISION OF VITAL RECORDS, 301 W. FREDERICK ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL, ITEM 8, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETURN PAGE 3 TO YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSMITTAL. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. FREDERICK STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR OF ESTIMATED DEATH			2c. DATE PRONOUNCED DEAD			2d. HOUR		
THOMAS WAYNE WOOD, Jr.			1/5/86			1/5/86			1/5/86			3:00 pm		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH							
Male	Caucasian	3/14/75	10 YRS.	MD	USA	<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> MARRIED	CHARLES							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY					
Bryans Road			100 Strawberry Drive			Student			School					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
MD			Charles			Waldorf			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			4517 Grouse Place		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT		
THOMAS WAYNE WOOD, SR.			CATHERINE ANN KYLE			NO.			None			Catherine A. Wood		
18. CAUSE OF DEATH			19. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			21a. EXTERNAL CAUSE WAS			21b. TIME OF INJURY		
PART I DEATH WAS CAUSED BY:			Metastatic Cancer			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21c. HOW INJURY OCCURRED		
IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF			21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION		
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.			(b)			WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>			AT HOME, STREET, FACTORY, FARM, ETC.			CITY OR TOWN		
(c)			DUE TO, OR AS A CONSEQUENCE OF			AT WORK			CITY OR TOWN			COUNTY		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).			22a. I certify that I took charge of the remains described above, held an			22b. DATE			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION		
			Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion			1/8/86			Trinity Memorial Gardens, Waldorf, Chas. MD			CITY OR TOWN		
			death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			ACTUAL SIGNATURE			DATE SIGNED			STATE		
			H.M. Mahan-Haft MD			JAN 9 1986			58th Box 1020 Capital MD 20646			COUNTY		
			EXAMINER'S NAME			ADDRESS			23a. BURIAL, CREMATION, REMOVAL			23b. DATE		
			H.M. Mahan-Haft MD			58th Box 1020 Capital MD 20646			Burial			1/8/86		
			Huntt Funeral Home, Waldorf, MD			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			23e. DATE		
			Huntt Funeral Home, Waldorf, MD			Trinity Memorial Gardens, Waldorf, Chas. MD			JAN 9 1986			COUNTY		

